STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155764	A. BUILDING	00	COMPLETED 12/14/2012
		133704	B. WING		
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP W 87TH AVE	CODE
SPRING	MILL HEALTH CA	MPUS		RRILLVILLE, IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	APPROPRIATE
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
1 10000					
	This visit was fo	or the Investigation of	F0000		
	Complaint IN00	0120199.			
	*	0120199-Substantiated.			
		ficiencies related to the			
		cited at F282, F314 and			
	F514.				
	This visit was in	n conjunction with the			
		visit (PSR) to the			
	_	Complaints IN00116313			
	_	3 completed on October 9,			
	2012.	5 completed on October 5,			
	2012.				
	This visit was in	n conjunction with the			
		visit (PSR) to the			
	1	Complaints IN00117692			
		2 completed on October			
	23, 2012.	•			
	Survey dates: I	December 12, 13, & 14,			
	2012				
	Facility a mul	010720			
	Facility number				
	Provider number: 2				
	Alivi number: 2	200830890			
	Survey team:				
	Janet Adams, R	N			
	Census Bed Typ	pe:			
	SNF: 41	•			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

XBPH11

PRINTED: 01/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155764		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR SNF/NF: 8 Residential: 58 Total: 107 Census payor tyl Medicare: 38 Medicaid: 5 Other: 64	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) De:	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	cited in accordar	es reflect state finding nce with 410 IAC 16.2. ompleted 12/20/12					

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Event ID: XBPH11

Facility ID: 010739

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155764	B. WIN			12/14/	2012
NAME OF B	AD CAMPED ON GAMPA ICE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		101 W 8	87TH AVE		
	MILL HEALTH CAN			MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=G	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services provide facility must be propersons in accord written plan of care Based on record facility failed to of care related to pressure relieving residents review the sample of 8. development of a ulcer and a Stage (Residents #B and Findings include 1. On 12/13/13 a was observed sitt unit Dining Room Multipodus boot. The record for R on 12/12/12 at 2 diagnoses include to, sickle cell and arthritis, congest vein thrombosis, multiple myelom.	review and interview, the follow the resident's plan of the implementation of g devices for 2 of 4 and for pressure ulcers in This resulted in the an unstageable pressure at 8:55 a.m., Resident #B ting in a wheel chair the m. The resident had blue is on both of her feet. Lesident #B was reviewed to 00 p.m. The resident's ted, but were not limited temia, brain tumor, ive heart failure, deep diabetes mellitus, and ma. The resident was	F02	**************************************	F282 1. Resident B was place on a pressure relieving mattress on 11/12/12. Resident C was discharged on 10/29/12. 2. All residents Care plans we updated on 12/28/12 for residwith specific approaches relate pressure relieving devices wer implemented and in place on. residents were re-assessed for risk potential and Care Plans were updated to reflect interventions for preventions. 3. License nurses were re-in serviced by Clinical Support and Medline representative concerning the need for implementation of pressure relieving devices. Nursing assistants were in-serviced regarding pressure prevention and healing interventions such turning and repositioning, hee elevated, w/c cushions and he boots. All residents will receivan admission assessment to ensure areas of skin impairme and risk areas have been identified, measured, appropria	ere ent ed e All r at as ls el ve nt	DATE 01/02/2013
	originally admitt	ed to the facility in 2010			treatment ordered, and		
		lmitted on 10/18/12.			prevention interventions		
	Review of the 10	0/18/12 Nursing			executed. Each area of impairment shall have a skin sheet to monitor progress wee	kly	

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Event ID: XBPH11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155764	B. WIN			12/14/2012	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Admission Asse	ssment & Collection Data			and intervene as needed.		
	form indicated th	ne resident was admitted			Individualized care plans will b	е	
	at 1:00 p.m. The	e form indicated the			developed for each resident identified at risk within 24 hour	re of	
	_	l assistance of two staff			admission. The DHS or desig		
	_	nsfers, ambulation and			will audit each chart within 24		
	toileting. The fo				hours of admission to ensure a	an	
	_	as intact and skin plan of			individualized Care Plan was		
		•			initiated and interventions are		
		is on the form included			place. Weekly rounds and rev	riew	
	for the resident t				of documentation will be completed by clinical support		
	_	els to be elevated off			nurses to monitor skin integrity	,	
	surfaces, and pre	essure relieving devices to			identification of wounds, woun		
	be provided.				healing, treatment and preven		
					interventions. The License Nu	rse	
	A Skin Impairm	ent Circumstance			will be responsible to ensure		
	_	m was initiated on			pressure relieving devices are	in	
		orm indicated wounds			place upon admission, when there is skin impairment identif	fied	
		n the resident's right heel			or when resident is determined		
		kle. The 11/2012			be at- DHS or designee will a		
		nistration Record			3 resident per day 5 times per		
					week to include all three shifts	to	
		vere Physician orders			ensure the intervention for		
		2/12. The Physician			prevention of skin breakdown	is in	
		eanse the area to the left			place. 4. DHS or designee will monit	or	
	outer heel with v	vound cleanser, pat dry,			and report findings to QAA	Ö.	
	apply Santyl to v	wound bed, and cover the			committee for montioring mont	thly	
	area with a clear	dressing every day.			for 6 months or until 100%		
	There was anoth	er Physician's order to			compliance is obtained. QAA		
		a wipe to dry skin on the			monitor for any trends and ma		
		heel every shift. There			any modifications to the POC an necessary.	as	
	'	r for a Sapphire (a			5. Completion date 1/2/13.		
	speciality low ai	'			S. Completion date 1/2/10.		
	speciality low at	1 1055 Hauressj.					
	Two Pressure/St	asis/Arterial/Diabetic					
	Ulcer Assessmer	nt forms were initiated on					
	11/12/12. The fi	irst form indicated a an					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
TAU	Unstageable preson the resident's intact and black measured 5.0 cm recorded. The following as were recorded as 11/14/12- Unstage 6.5 cm in size, slower in si	right heel. The skin was in color and the area a x 6.5 cm with no depth seessments of the wound of follow: geable wound, 5.0 cm x kin intact, black in color geable wound, 5.0 cm x kin intact, blac		TAU			DATE	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 12/14	ETED
	PROVIDER OR SUPPLIER		•	101 W 8	DDRESS, CITY, STATE, ZIP CODE 57TH AVE LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	red color, 80% y 12/05/12- Stage undetermined de red, 5% yellow i 12/12/12- Stage undetermined de red in color When interviewe a.m., the Interim indicated the are heel and left ank 11/12/12. The In Nursing indicate pressure relievin the resident had	ellow in color III, 1.5 cm x 1.5 cm, pth, no drainage, 95% n color III, 1.0 cm x 0.8 cm, pth, no drainage, 100% ed on 12/13/12 at 11:00 Director of Nursing as to the resident's right le were first observed on nterim Director of d the facility ordered a g mattress at that time as identified risk factors					
	Director of Nurs the resident was not a pressure re 2. The closed re reviewed on 11/2 resident was adn the hospital on 1 was discharged to 10/29/12. The rincluded, but we mellitus, high blacute kidney injunatherosclerotic discontinuous discharged to 10/29/12.	cord for Resident #C was 13/12 at 9:00 a.m. The nitted to the facility from 0/19/12. The resident of the hospital on resident's diagnoses are not limited to, diabetes food pressure, history of arry, spinal stenosis, isease, diabetic fory of anemia, and					

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PRINTED: 01/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155764		LDING		12/14/	
		-	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS			_LVILLE, IN 46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)		TAG	BEFFEERET		DATE
	The 10/19/12 No	rsing Admission					
		ata Collection form was					
		orm indicated the resident					
	was admitted at						
		form also indicated the					
	resident required						
	•	ers, bathing, dressing,					
		ing. The form also					
	•	ident had a Stage I or					
		nd the corresponding					
	_	dicated a Stage II wound					
		ne sacral/coccyx area and					
	26 staples were r	noted along the spinal					
	column. The Sk	in Plan of Care on the					
	form indicated th	ne resident was to have a					
	pressure relievin	g device to the bed. An					
	Assessment Rev	iew and Considerations					
	form was comple	eted on 10/19/12. This					
	form indicated th	ne resident had mobility					
	impairment and	medical diagnoses					
	affecting skin ox	ygenation which were					
	risk factors that	contributed to the					
	potential for skir	breakdown.					
	Two Pressure/St	asis/Arterial/Diabetic					
	Ulcer Assessmer	nt forms were initiated on					
	11/12/12. The fi	rst form indicated a					
	Stage III (an ulce	er with full thickness					
	tissue loss witho	ut bone, tendon, or					
		pressure ulcer was					
	present on the re	sident's coccyx and the					
	color of the wou	nd was yellow. The					
	pressure ulcer m	easured 3.0 cm x 1.0 cm					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED
	PROVIDER OR SUPPLIER		STREET A 101 W 8	DDRESS, CITY, STATE, ZIP CODE 87TH AVE LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)		COMPLETION DATE
TAG	with depth of 0.5 wound assessme form: 11/14/12- Stage undetermined de yellow, no draina 11/21/12- Stage undetermined de 40% yellow, no 61/28/12- Stage undetermined de 20% yellow, no 61/25/12- Stage II undetermined de 10% yellow, no 61/25/12- Stage wound 100% recent 11/21/12- Stage wound 100% recent 11/28/12- Area in 11/2	ints were recorded on the III, 2.5 cm x 1.0 cm, pth, wound color 100% age III, 1.0 cm x 0.8 cm, pth, wound 60% red and drainage. III, 1.0 cm x 0.6 cm, pth, wound 80% red, drainage II, 1.0 cm x 0.6 cm, pth, wound 90% red, drainage II, 1.0 cm x 0.6 cm, pth, wound 90% red, drainage III, 1.0 cm x 0.6 cm, pth, wound 90% red, drainage. III as present on the nner buttock. The wound II x 1.0 cm and was red in owing wound assessments in the form: III, 2.5 cm x 1.0 cm, II, no drainage present. III, 0.5 cm x 0.3 cm, II, no drainage present.	TAG			DATE
	had multiple Sta	relieving mattress if they ge II pressure ulcers, er ulcer, high risk factors,				

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		ATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 12/14/2012				
	ROVIDER OR SUPPLIER MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				
	or were on bedrest.								
	This federal tag relates to IN00120199.	Complaint							
	3.1-35(g)(2)								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155764	B. WINC			12/14/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				B7TH AVE		
	MILL HEALTH CAN			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0314 SS=G		CS TO PREVENT/HEAL					
	a resident, the factoresident who enterpressure sores do sores unless the incondition demons unavoidable; and sores receives neservices to promoting to the faction and previous developing. Based on observation interview, the factores are relieving for residents ider ulcers or at risk for pressure ulcers for reviewed for presonant unstageable possible. This results an unstageable possible possibl	inprehensive assessment of cility must ensure that a gers the facility without been not develop pressure individual's clinical strates that they were a resident having pressure excessary treatment and ote healing, prevent went new sores from ation, record review, and cility failed to ensure g devices were in place intified with pressure for the development of for 2 of 4 residents assure ulcers in the sample ed in the development of ressure ulcer and a Stage r. (Residents #B and #C). failed to ensure the nents were in place for ultiple pressure ulcers for reviewed for pressure uple of 8. (Residents #C	F03	14	F314 1. Resident B was place a pressure relieving mattress of 11/12/12. Resident C was discharged on 10/29/12. Resident E was discharged on 12/15/122. All residents Care plans were updated on 12/28/for resident with specific approaches related pressure relieving devices were implemented and in place on. residents were re-assessed for risk potential and Care Plans were updated to reflect interventions for preventions. Since the concerning the need for implementation of pressure relieving devices. Nursing assistants were in-serviced regarding pressure preventions and healing interventions such as turning and repositioning, heels elevated, w/c cushions a heel boots. All residents will	All rat 3. and	01/02/2013
	was observed situnit Dining Room	ting in a wheel chair the			heels elevated, w/c cushions a		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155764	A. BUI. B. WIN			12/14/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF F	PROVIDER OR SUPPLIER	L Company of the Comp			87TH AVE		
SPRING	MILL HEALTH CAN	//PUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	The record for R on 12/12/12 at 2 diagnoses include to, sickle cell and arthritis, congest vein thrombosis, multiple myelom originally admitted and was last read. Review of the 10 Admission Asseform indicated that 1:00 p.m. The resident required members for transtoileting. The form the resident to repositioned, her surfaces, and president to provided. A Skin Impairmed Investigation for 11/12/12. The form were observed of and left outer and Treatment Admit indicated there were sincered to the resident of	esident #B was reviewed 100 p.m. The resident's 10d, but were not limited 10d, but were not limi		TAG	to ensure areas of skin impairment and risk areas have been identified, measured, appropriate treatment ordered and prevention interventions executed. Each area of impairment shall have a skin sheet to monitor progress were and intervene as needed. Individualized care plans will be developed for each resident identified at risk within 24 hours of admission. The DHS or design will audit each chart within 24 hours of admission to ensure a individualized Care Plan was initiated and interventions are place. Weekly rounds and revort of documentation will be completed by clinical support nurses to monitor skin integrity identification of wounds, woun healing, treatment and preven interventions. The License Nurwill be responsible to ensure pressure relieving devices are place upon admission, when there is skin impairment identification of skin breakdown there is skin include all three sto ensure the intervention for prevention of skin breakdown place. 4. DHS or designee with monitor and report findings to QAA committee for montioring monthly for 6 months or until 100% compliance is obtained. QAA will monitor for any trend and make modifications to the	ve I, ekly be rs of inee an in view y, id tion rse in fied d to will es hifts is in II	DATE
		-				9	
	orders were to c	eanse the area to the left			POC as necessary. 5.		

i i			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155764	B. WIN			12/14/	2012
(F. 0.F. n			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			101 W 8	B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	outer heel with v	vound cleanser, pat dry,			Completion date 1/2/13.		
		vound bed, and cover the					
		dressing every day.					
		er Physician's order to					
		a wipe to dry skin on the					
		heel every shift. There					
		r for a Sapphire (a					
	speciality low air	r loss mattress).					
		asis/Arterial/Diabetic					
	Ulcer Assessmer	nt forms were initiated on					
	11/12/12. The fi	rst form indicated a an					
	Unstageable pres	ssure ulcer was observed					
	on the resident's	right heel. The skin was					
	intact and black	in color and the area					
	measured 5.0 cm	x 6.5 cm with no depth					
	recorded.	r					
		ssessments of the wound					
	were recorded as						
		geable wound, 5.0 cm x					
	`	kin intact, black in color					
	1						
		geable wound, 5.0 cm x					
		kin intact, black in color					
	l '	geable wound, 5.0 cm x					
	· ·	kin intact, black in color					
	12/05/12- Unstaș	geable wound, 5.0 cm x					
	6.5 cm in size, sl	kin intact, black in color					
	12/12/12- Unstag	geable wound, 5.0 cm x					
		kin intact, black in color					
	The second form	indicated a Stage III					
	pressure ulcer wa	as identified on the left					
	_	the wound measured 2 cm					
		epth recorded. The					
		7 10001404. 1110					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/14/	ETED	
	PROVIDER OR SUPPLIER		p. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE B7TH AVE LLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	applied. The following as were recorded as 11/14/12- Stage undetermined de in color, treatme 11/21/12- Stage undetermined de red color, 80% y 11/28/12- Stage undetermined de red color, 80% y 12/05/12- Stage undetermined de red, 5% yellow i 12/12/12- Stage undetermined de red in color When interviewe a.m., the Interim indicated the are heel and left ank 11/12/12. The In Nursing indicate pressure relievin the resident had noted prior to 11 Director of Nurs the resident was not a pressure re	III, 1.5 cm x 1.5 cm, 19th, no drainage, yellow nt with Santyl. III, 1.5 cm x 1.5 cm, 19th, no drainage, 20% ellow in color III, 1.5 cm x 1.5 cm, 19th, no drainage, 20% ellow in color III, 1.5 cm x 1.5 cm, 19th, no drainage, 20% ellow in color III, 1.5 cm x 1.5 cm, 19th, no drainage, 95% ellow in color III, 1.0 cm x 0.8 cm, 19th, no drainage, 100% ellow in color III, 1.0 cm x 0.8 cm, 19th, no drainage, 100% ellow in color III, 1.0 cm x 0.8 cm, 19th, no drainage, 100% ellow in color III, 1.0 cm x 0.8 cm, 19th, no drainage, 100% ellow in color in co					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155764	B. WIN	G		12/14/2	2012
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			101 W 8	37TH AVE		
	MILL HEALTH CAN			<u> </u>	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ГЕ	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY,		DATE
		mpleting a wound care					
		sident #E. The LPN					
		ing from the residents					
		amount of bloody					
	_	served on the dressing.					
	_	was observed to the					
	resident's coccyx	x. The open area					
	measured approx	kimately 1 cm					
	(centimeter) x .5	cm with a red center.					
	No odor was not	ed. There were no other					
	open areas on the	e resident's coccyx or					
	buttock areas.	, and the second					
	The record for R	esident #E was reviewed					
		:30 p.m. The resident's					
		led, but were not limited					
	"	ressure, left hip fracture,					
		•					
		disease, chronic kidney					
	1	ive heart failure, open toe					
	·	ous insufficiency. The					
		nitted to facility from the					
	hospital on 11/6/	/12.					
	Review of the 10)/24/12 hospital					
		ecords indicated the					
		ecubitus (pressure ulcer)					
		and was receiving					
	wound care.						
	Review of the 11	1/6/12 admission					
		indicated there were					
	*	Santyl (an ointment to					
		o the right great toe two					
	umes a day and a	also apply Silvadene (an					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155764		LDING	00	12/14/	
		133704	B. WIN			12/14/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			37TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		wounds) cream to the					
		o times a day. There					
	were no Physicia	_					
	treatment to the	coccyx or buttock areas.					
		er was written on					
	11/12/12 to clear	nse the area on the					
	resident's coccyx	with wound cleanser,					
	pat dry, and appl	y Santyl to the wound					
	bed and cover th	e area every other day.					
	Review of the 11	./6/12 (no time					
	documented) Nu	`					
	· · · · · · · · · · · · · · · · · · ·	ata Collection form					
		ident had a left hip					
		aired assistance with					
	•	ation, bathing, toileting,					
		ne form also indicated the					
		nave a Stage I wound or					
		nd the resident was not at					
	,	ng pressure ulcers. There					
	_	ram on the Nursing					
		ssment & Data Collection					
		skin impairments					
	<u> </u>	nly areas marked on					
		oruise to the resident's					
	_	to the left hip area. The					
		e on the form did not					
		re relieving device was to					
	_	e resident's bed. An					
	_	iew and Considerations					
		on 11/6/12 indicated staff					
	_	he resident had risk					
		ty impairment, past					
		, i					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155764	B. WIN	G		12/14/2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI LIER				B7TH AVE	
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG				TAG	DEFICIENCE!	DATE
	_	cal diagnoses affecting				
	''	n. None of the above				
		xed as being applicable to				
	the resident.					
	A Skin Impairm	ent Circumstance,				
		Intervention form was				
		2/12 (no time listed).				
		ted the resident had two				
		r with partial thickness				
		lermis with a red or pink				
		are ulcers. The pressure				
		ed on the resident's left				
		d the coccyx areas.				
	inner outlock un	d the coceyx dreas.				
	Two Pressure/St	asis/Arterial/Diabetic				
	Ulcer Assessmer	nt forms were initiated on				
	11/12/12. The fi	irst form indicated a				
	Stage III (an ulc	er with full thickness				
		ut bone, tendon, or				
	muscle exposed)	pressure ulcer was				
		sident's coccyx and the				
	_	nd was yellow. The				
		easured 3.0 cm x 1.0 cm				
		5 cm. The following				
	_	nts were recorded on the				
	form:					
		III, 2.5 cm x 1.0 cm,				
	1	epth, wound color 100%				
	yellow, no drain	* '				
	*	III, 1.0 cm x 0.8 cm,				
		epth, wound 60% red and				
	40% yellow, no	•				
	11/28/12- Stage	III, 1.0 cm x 0.6 cm,				

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i '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155764	B. WIN	G		12/14/2012
NAME OF P	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE	
000000		451.10			B7TH AVE	
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
		epth, wound 80% red,				
	20% yellow, no	· ·				
		II, 1.0 cm x 0.6 cm,				
		epth, wound 90% red,				
	10% yellow, no	drainage.				
	The good form	aindicated a Store II				
		indicated a Stage II				
	pressure ulcer w					
	~	nner buttock. The wound a x 1.0 cm and was red in				
		owing wound assessments				
	were recorded or					
	_	II, 2.5 cm x 1.0 cm,				
		l, no drainage present.				
		II, 0.5 cm x 0.3 cm,				
		l, no drainage present.				
	11/28/12- Area	resolved.				
	Review of the 11	1/13/12 Nutrition				
		Data Collection form				
		gistered Dietitian noted				
	·	e had a wound to the				
		months. The form also				
		ident currently had open				
		yx, left upper buttock,				
		be. The Registered				
	1	nmendations included to				
		lent's oral intake and add				
		Nutritional Supplement				
	unee umes a day	for skin healing.				
	When interviewe	ed on 12/13/12 at 11:00				
		Director of Nursing				
		ident's open area to the				
	mulcated the les	ident's open area to the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(A2) M	ULTIPLE CO	OO	(X3) DATE : COMPL		
ANDILAN	OI CORRECTION	155764	A. BUII		00	12/14/	
		100107	B. WIN		DDDDGG GUTY GT TT	12/14/	_ · · · · ·
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAM	MPUS			LVILLE, IN 46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
		ent and not identified					
		The Interim Director of					
	•	d the coccyx wound was					
		11/121/2 when the					
		d skin checks for the					
		terim Director of Nursing					
	•	ssure ulcer was a Stage					
	III when it was f						
		and a specialty low air					
		re ordered at that time					
		ector of Nursing indicated					
		have a low air loss or					
		g mattress if they had					
		pressure ulcers, Stage III					
	_	nigh risk factors, or were					
		Interim Director of					
	_	d the resident had been					
	_	Health care before his					
	-	nd had the wound then.					
		ector of Nursing indicated					
	the resident shou						
		wound upon admission.					
		ector of Nursing indicated					
		risk factors such as					
	mobility impairn						
	_	ng skin oxygenation					
	•	and this should have been all assessment form. The					
		of Nursing indicated the					
	_	g devices should have					
	_	on admission for a Stage					
	III pressure ulcer						
	3. The closed re-	cord for Resident #C was					

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i '			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING	00	COMPL	
		155764	B. WING			12/14/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					37TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		13/12 at 9:00 a.m. The					
		nitted to the facility from					
		0/19/12. The resident					
	was discharged t	_					
		esident's diagnoses					
	•	re not limited to, diabetes					
		ood pressure, history of					
	1	ıry, spinal stenosis,					
	atherosclerotic d						
	neuropathy, histo	ory of anemia, and					
	peripheral artery	disease.					
	The 10/19/12 Nu	rsing Admission					
	Assessment & D	ata Collection form was					
	reviewed. The f	orm indicated the resident					
	was admitted at	6:40 p.m. via an					
	ambulance. The	form also indicated the					
	resident required	assistance with					
	grooming, transf	ers, bathing, dressing,					
	eating, and toilet	ing. The form also					
	indicated the res	ident had a Stage I or					
	greater wound as	nd the corresponding					
	body diagram in	dicated a Stage II wound					
	was present on the	he sacral/coccyx area and					
	26 staples were i	noted along the spinal					
	_	in Plan of Care on the					
	form indicated th	ne resident was to have a					
	pressure relievin	g device to the bed. An					
	_	iew and Considerations					
	form was comple	eted on 10/19/12. This					
	1	ne resident had mobility					
		medical diagnoses					
	-	ygenation which were					
	_	contributed to the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ULTIPLE CO		(X3) DATE COMPL			
MOLLAN	OI COMMECTION	155764		LDING	00	12/14/	
		100101	B. WIN		ADDRESS CITY OF ATE OF CORE	12,14/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	//PUS			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG				TAG	DLI TELLACT)		DATE
	potential for skir	i breakdown.					
	There were two	Pressure/Stasis/Diabetic					
		nt forms completed for					
		e first form indicated an					
		ssure ulcer was first					
		resident's coccyx upon					
		facility on 10/19/12.					
		er measured 5.5 cm x 1					
	•	f 0.2 cm, the wound bed					
	•	n color, no drainage was					
	_	eatment being used was					
	Santyl ointment.	-					
	•	vound assessment was					
	recorded:						
	10/24/12 -Unstag	geable, measuring 7.6 cm					
	x 6 cm with unde	etermined depth,					
	moderate amoun	t of bloody drainage,					
	wound bed with	50% red, 50% slough, no					
	odor noted, and						
	the treatment wa	s Santyl. The section on					
		current preventative					
	interventions" w						
		orther assessments of the					
	wound recorded	on the form.					
	The second form	indicated a Stage II					
		as first observed on the					
	_	nner gluteus upon					
		facility on 10/19/12.					
		neasurements recorded,					
		wound was red, no odor					
		he treatment being used					
	was Santyl.	5					
	<u> </u>						

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		12/14/	2012
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIEN				37TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ound assessment was					
	recorded:						
	1	II, measuring 2 cm x 1.2					
		n 0.1 cm depth, the					
	wound was 100%	% red and no drainage or					
	· ·	the treatment being used					
	was Santyl. The	section on the form titled					
	"current preventa	ative interventions" was					
	blank.						
	There were no fu	irther assessments of the					
	wound recorded	on the form.					
	Review of the 10	0/19/12 admitting					
		indicated there was an					
		the wound to the coccyx					
		h, pat dry, and apply					
		ptifoam(a type of					
		e were no Physician					
	- ·	d care to the right inner					
	gluteus area.	deare to the right filler					
	giuleus alea.						
	Paview of the 10	0/2012 Treatment Record					
		ove ordered treatment was					
		ing completed. There					
	~	• •					
		itation of any treatment					
		on the right inner gluteus					
	wound.						
	When intervio	ed on 12/13/12 at 11:00					
		Director of Nursing					
		nts were to have a low air					
	_	relieving mattress if they					
		ge II pressure ulcers,					
	Stage III or high	er ulcer, high risk factors,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764				LDING	NSTRUCTION 00	(X3) DATE COMPI 12/14	
	PROVIDER OR SUPPLIER		<u> </u>	101 W 8	DDRESS, CITY, STATE, ZIP CODE 87TH AVE LVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	When interviewed p.m., the Interim indicated the resulcer as per the wand there should order for each widifferent stages. Nursing also ind to the right glute measured upon a Director of Nursisheets noted trea areas was Santyl Nursing indicate resident's with prorious air loss mappear the resider relieving mattres had in place due factors.	ed on 12/13/12 at 1:45 Director of Nursing ident had two pressure wound assessment sheets have been a separate ound as they were. The Interim Director of icated the pressure ulcer al area should have been admission. The Interiming indicated the wound tment being done to the . The Interim Director of dishe had a listing of ressure relieving specialty eattress and it did not ent had a pressure is which she should have to her wounds and risk.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155764	A. BUII B. WIN			12/14/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS	MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		PLETE/ACCURATE/ACCE					
	SSIBLE						
	-	maintain clinical records on					
		accordance with accepted					
	· ·	dards and practices that curately documented;					
		e; and systematically					
	organized.	o, and systematically					
	o.gaoa.						
	The clinical recor	d must contain sufficient					
	information to ide	ntify the resident; a record					
	of the resident's a	assessments; the plan of					
		s provided; the results of					
		screening conducted by					
	the State; and pro	_					
	Based on record	review and interview the	F05	14	F514		01/02/2013
	facility failed to	ensure clinical records			Resident C was discharged	lon	
	were complete re	elated to the			10/29/12. 2. All residents with presure		
	documentation o	of Physician and family			ulcers were assessed on		
	notification of ch	nanges in pressure ulcer			12/28/12 to ensure Physician a	and	
		1 of 4 residents reviewed			family notification of changes i	n	
	with pressure uld	cers in the sample of 8.			pressue ulcer assessment. Ar	-	
	(Resident #C)	•			deficiencies noted were correct at this time.	tea	
	/				3. License nurses were		
	Findings include				re-inserviced on 12/28/12 on		
	i mamga merude	·•			notification of Physician and		
	701 1 1	1.C. D. :1 4 // C			families of changes in pressure	е	
		rd for Resident #C was			ulcer assessments All		
		13/12 at 9:00 a.m. The			residents will receive an		
	resident was adn	nitted to the facility from			admission assessment to ensu		
	the hospital on 1	0/19/12. The resident			areas of skin impairment and r	ISK	
	was discharged t				areas have been identified,	ont	
	_	resident's diagnoses			measured, appropriate treatme ordered, and prevention	21 IL	
		_			interventions executed. Weel	klv	
		re not limited to, diabetes			rounds and review of	v. y	
	, ,	ood pressure, history of			documentation will be complet	ed	
	acute kidney inju	ıry, spinal stenosis,			by clinical support nurses to		
			<u> </u>			ļ	

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		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
THIS TELLY OF COLUMN	155764	A. BUILDING		12/14/2012
PREFIX (EACH I REGULA' atheroscle neuropath periphera The 10/19 Assessme reviewed was admi ambulance resident regrooming	IDENTIFICATION NUMBER: 155764 SUPPLIER	A. BUILDING B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE LLVILLE, IN 46410 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) monitor skin integrity, identification of wounds, woun healing, treatment and preveninterventions. DHS or design will audit all resident with wou documention weekly to ensure notification to Physican and families of any change of in assessment. 4. DHS or designee will monit and report findings to QAA committee for montioring monit for 6 months or until 100% compliance is obtained. QAA monitor for any trends and material control of the control	COMPLETED 12/14/2012 (X5) COMPLETION DATE d tion ee end et cor thly will
indicated greater work body diag was prese 26 staples column. There we Ulcer Ass the reside Unstageal observed admission The press cm with a was red/y noted, and Santyl oir The following recorded: 10/24/12	the resident had a Stage I or ound and the corresponding gram indicated a Stage II wound ant on the sacral/coccyx area and a were noted along the spinal are two Pressure/Stasis/Diabetic resessment forms completed for int. The first form indicated an oble pressure ulcer was first on the resident's coccyx upon in to the facility on 10/19/12. The first form indicated an oble pressure ulcer was first on the resident's coccyx upon in the facility on 10/19/12. The first form indicated and the facility on 10/19/12 are ulcer measured 5.5 cm x 1 depth of 0.2 cm, the wound bed ellow in color, no drainage was did the treatment being used was			ake

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED			
155764		B. WING			12/14/2012				
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE				
				101 W 87TH AVE					
SPRING MILL HEALTH CAMPUS				MERRIL	LVILLE, IN 46410				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	re C	OMPLETION DATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAG	Birtelinery		DATE		
	moderate amount of bloody drainage, wound bed with 50% red, 50% slough, no odor noted, and the treatment was Santyl. The section on the form titled "current preventative interventions" was blank.								
	There were no further assessments of the								
	wound recorded on the form.								
	would recorded on the form.								
	The second form	indicated a Stage II							
		as first observed on the							
	resident's right inner gluteus upon								
		facility on 10/19/12.							
		neasurements recorded,							
	the color of the wound was red, no odor								
	was noted, and the treatment being used was Santyl.								
	The following w	ound assessment was							
	recorded:								
	10/24/12- Stage	II, measuring 2 cm x 1.2							
	cm with less the	n 0.1 cm depth, the							
	wound was 100%	% red and no drainage or							
	odor noted, and	the treatment being used							
	1	section on the form titled							
	"current preventa	ative interventions" was							
	blank.								
		arther assessments of the							
	wound recorded	on the form.							
		127							
	Review of the N								
		llow up documentation							
		vas no documentation of							
		ysician or family being							
	notified of the cl	nange in the assessment							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		A. BUIL	A. BUILDING B. WING			COMPLETED 12/14/2012			
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE			
	of the resident's coccyx wound on 10/24/12.								
	When interviewed on 12/13/12 at 1:50 p.m., LPN #2 indicated she measured and assessed the resident's pressure ulcers on 10/24/12. The LPN indicated she informed the Physician of the change and no orders were given. The LPN indicated she also informed the resident's family. LPN #2 indicated she did not document the notification of the family and Physician in the resident's clinical record. This federal tag relates to Complaint IN00120199. 3.1-50(a)(1) 3.1-50(a)(2)								

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